VERMONT

State of Vermont *Agency of Human Services*
Department of Vermont Health Access
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REQUEST FOR AIRWAY CLEARANCE DEVICES

PLEASE COMPLETE BOTH EVALUATION SEGMENTS DURING THE TRIAL

PLEASE SUBMIT COMPLETED FORM TO DME PROVIDER

Patient Name: _____ Date of Birth: _____/_____/_____

Member ID#: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____

Patient Address: _____ City, State, Zip code: _____

Physician Name: _____ Physician NPI: _____Medicaid Provider Number: _____

Physician Address: _____ City, State, Zip code: _____

Physician Phone #: _____ Physician Fax#: _____

Physician Signature: _____

Durable Medical Equipment (DME) Requested:

DME Description: _____ HCPCS code: _____
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For Airway Oscillating Devices and Mechanical Percussors: 1.Does the patient have cystic fibrosis/CF, chronic bronchitis, bronchiectasis, immotile cilia syndrome, or asthma?	☐Yes ☐No Comments:
For Positive Expiratory Pressure/PEP Masks: 1.Does the patient have CF, chronic bronchitis, immotile cilia syndrome, asthma, or chronic obstructive pulmonary disease/COPD?	☐Yes ☐No Comments:
For High-Frequency Chest Compression Systems:	
1.Has the patient failed standard treatments to adequately mobilize retained secretions?	☐Yes ☐No Comments:
2.Does the patient have bronchiectasis confirmed by CT scan characterized by daily productive cough for at least 6 months or by frequent (more than 2 times per year) exacerbations requiring antibiotic therapy?	☐Yes ☐No Comments:
3.Does the patient have cystic fibrosis or immotile cilia syndrome?	☐Yes ☐No Comments:
4.Is the patient within the first 6 months post-operatively following lung transplant and unable to tolerate standard chest physiotherapy?	☐Yes ☐No Comments:

5.Does the patient have one of the following neuromuscular diseases?	☐Acid maltase deficiency ☐Hereditary muscular dystrophy ☐Anterior horn cell disease, including amyotrophic lateral sclerosis ☐Multiple Sclerosis ☐Myotonic disorder ☐Paralysis of the diaphragm ☐Post-polio ☐Quadriplegia ☐Other myopathies
For Mechanical In-Exsufflation Devices: 1.Does the patient have a neuromuscular disease that is causing a significant impairment of chest wall and/or diaphragmatic movement and for whom standard treatments have not been successful in adequately mobilizing retained secretions?	☐Yes ☐No Comments:

There must be well-documented failure of standard treatments to adequately mobilize retained secretions:

Document trial/consideration of each applicable device/technique trialed listed below, AND why it was not successful for the beneficiary.

☐CPT (Manual or Percussor) ☐PEP ☐Flutter/Acapella ☐Cough Assist ☐Breathing/Drainage Techniques
☐No Caregiver Available ☐Physical Limitations of Caregiver ☐GERD ☐Physical Limitations of Patient ☐Did not Mobilize Secretions ☐Young Age
☐Too Fragile for Percussion ☐Resistance to Therapy ☐Aspiration Risk ☐Can't Tolerate Positioning ☐Insufficient Expiratory Force ☐Artificial Airway
☐Severe Arthritis/Osteoporosis ☐Kyphosis/Scoliosis ☐Cognitive Level ☐Spasticity/Contractures ☐Inability to Form Mouth Seal
☐Other_____
Reason for failure:

Trial Period- item requested must have a 3-month trial period.	First Evaluation: Baseline ____/_____/_____	Final Evaluation (at least 3 months from first): final determination of device efficacy ____/_____/_____
Prescription for device use (include minutes/day):		
Hospitalizations including dates and reason for admission or IV antibiotic therapy including dates and reason:		
Requires assistance to mobilize:	☐Yes ☐No ☐ N/A	☐Yes ☐No ☐N/A
Adequate physiological cough reflex:	☐Yes ☐No ☐N/A	☐Yes ☐No ☐ N/A
Pulmonary Functions: (please attach results)	Pre use of device:	With device use:
Daily productive cough: Duration in months:	☐Yes ☐No _____	☐Yes ☐ No _____
Is member ventilator dependent:	☐Yes ☐No	☐Yes ☐No
Is there assistance of a caregiver in the home:	☐Yes ☐No	☐Yes ☐No
Documented adherence to therapy is required: (please attach data chart)	☐Yes ☐No	☐Yes ☐No
Education provided to member and family if applicable:	☐Yes ☐No	☐Yes ☐No
Specify brands trialed:		
Other Pertinent Information:		
MD Signature:		